Map 10
(Rev 7/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
WAIVER SERVICES
PHYSICIAN'S RECOMMENDATION

PLEASE RETURN TO THE REQUESTOR LISTED BELOW.

_____
(Requestor's Name)

_____
(Address)

_____ **KY**_____ _____
(City) **(Zip)** **(Phone)**

PHYSICIAN'S RECOMMENDATION

I recommend Waiver services for:

_____ _____
(Member) **(Social Security #)**

_____
(Address)

_____ **KY**_____ _____
(City) **(Zip)** **(Phone)**

DIAGNOSIS (ES): _____

_____

Recommended Waiver Program:

- ☐ HCBW (ARNP, PA or Physician signature)
- ☐ ABI Waiver – Services to adults with acquired brain injury (21–65 yrs) with a potential for rehabilitation and retraining (Physician signature)
- ☐ SCL Waiver (SCL QMRP or Physician signature)
- ☐ Michelle P. Waiver – Non-residential Services to children and adults with mental retardation or developmental disabilities. (ARNP, QMRP, PA or Physician signature)

I certify that if Waiver services were not available, institutional placement in a Nursing Facility delete (NF) or Intermediate Care Facility for the Mentally Retarded/Developmentally Disabled shall be appropriate for this member in the near future.

_____ _____
(Authorized Signature) **(Date)**

_____ _____
(Printed Name) **(UPIN#)**

_____
(Address)

_____ **KY**_____ _____
(City) **(Zip)** **(Phone)**

Kentucky
UNBRIDLED SPIRIT